emailed validation letter 3/31/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 3.15.11
Amount $1860.
CK # 04685

I. IDENTIFICATION

Name LP Beattyville, LLC d/b/a Lee County Care & Rehabilitation Center

Address 249 East Main Street

City/County/Zip Beattyville, KY 41311-9249

Telephone number 606-4643611

Administrator Glenn E. Cox

RECEIVED
MAR 15 2011
OFFICE OF INSPECTOR GENERAL

Date facility operation began at current address _____

Date facility began operation under current owner November 1, 2007

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	~~120~~ 124	~~120~~ 124
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	**Profit**	Individual
County	Nonprofit	Partnership
City		Corporation
Private		**LLC**

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

N/A

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation LP Beattyville, LLC

Address of corporation 12201 Bluegrass Parkway, Louisville, KY 40299

President or Chairman N/A

Vice President N/A

Secretary N/A

Treasurer N/A

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility. **None**

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. **None**

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner. **None**

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
Signature HealthCARE, LLC	Signature Consulting Service, LLC Signature Clinical Consulting Services, LLC
12201 Bluegrass Parkway	12201 Bluegrass Parkway
Louisville, KY 40299	Louisville, KY 40299

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative	Title	Date
	CFO	3/16/11

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)